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ABSTRACT

Play therapy can be used to help children with disabilities to develop a sense of strength and competency. Play therapy literature concerning children with disabilities is divided into two distinct approaches: (1) the "I am" attribute which deals with emotional adjustment and helps the child to develop positive self-esteem, personal competency, and self-reliance; and (2) the "I can" attribute which deals with physical activity and is related to feelings of competence and control of circumstances. Play therapy focusing on emotional development can be nondirective (person-centered), which does not have specific activities planned, or directive, which uses specific activities selected by the therapist. Play therapy aimed at physical development may involve intensive play, coordination and motor skill activities, and therapeutic toys. Accommodations for children with disabilities can involve adaptation of toys and adaptations in the child's setting. The paper recommends that play therapy be considered in the overall treatment plan by mental health and pediatric nurses; that the professional play therapist work with the treatment team; and that the parents be involved in treatment. (Contains 39 references.) (JDD)

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PLAY THERAPY FOR CHILDREN WITH DISABILITIES

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Abstract

Play therapy allows children with disabilities to discover what they can do and who they are. Play therapy may be directive or nondirective, emotionally or physically focused. Suggestions for specific activities are presented for providing play therapy for children with disabilities.

Play Therapy for Children with Disabilities

Children with disabilities have long been recognized as having special emotional concerns related to their disabilities. Some of these emotional concerns have been identified by Williams and Lair (1991) as lack of self-confidence, decisions making skills, and feelings of inadequacy. The greatest challenges are not the challenges of the disabilities, but rather the feelings of inadequacy and rejection (Li, 1983).

Play therapy, while not a solution to all of the child's problems, is one method used to help the child with disabilities to develop a sense of strength and competency. Through play the child explores the I am and the I can characteristics of personality development. The I can attribute is related to feelings of competence and control of circumstances. The I am attribute helps the child to develop positive self-esteem, personal competency, and self-reliance in relation to specific circumstances (Eyde & Menolascino, 1981).

Play therapy literature concerning children with disabilities is divided into two distinct approaches.

The first approach primarily emphasizes the emotional adjustment, or the I am (Bernhardt & Mackler, 1975; Bradley, 1970; Buse, Cole, Rubin, & Fletcher, 1988; Davidson, 1975; Eyde & Menolascino, 1981; Gardner, 1974, 1975; Irwin & McWilliams, 1974; Landreth, Jacquot & Allen, 1969; Li, 1981; Morrison & Newcomer, 1975; Newcomer & Morrison, 1974). The I am attribute is usually provided by counselors, psychologist, social workers, or other mental health providers (Axline, 1948, 1964; Jolly, 1979; Landreth, 1991; Reineck, 1983; Salomon, 1983; Williams & Lair, 1991). The second approach primarily emphasizes physical activity or the I can (Bradtke, Kirkpatrick, and Rosenblatt, 1972; Chorost, 1988; Kraft, 1981, 1983; Lambie, 1975; Marlowe, 1979; Roswal, 1983; Roswal, Frith, & Dunleavy, 1984). The I can emphasis is usually provided by occupational therapists, child life specialists, recreational therapists, and physical therapists (Anderson, Hinojosa & Starch, 1987; Brien, 1977; Darbyshire, 1980; Lilly & Powell, 1990; Palumbo, 1988, 1989).

I AM EMPHASIS

The I am emphasis focuses on the emotional development of the child. The I am emphasis of play

therapy for children with disabilities has been addressed in two methods of play therapy; nondirective and directive. Nondirective or person-centered play therapy has been described by Landreth (1991)

> "as a dynamic interpersonal relationship between a child and a therapist...who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self..."(p.14).

Person-centered play therapy does not have specific activities for the child. The child spontaneously plays with a selection of toys representing household objects, transportation, wild and domestic animals, aggression toys, doll family, community helper dolls, puppets, creative art supplies, and throwing toys. The therapist provides the core conditions of empathy, warmth and genuine respect for the child. The therapist reflects the feelings expressed by the child's spontaneous, free play. The therapist is careful to not make judgmental statements about the child or the child's creative arts products. For example, the child shows the counselor an art project, the counselor would not comment on the quality of the work, but rather reflect the child's

feelings about its production. The person-centered approach is focused on the child's growth and development and his/her ability to know what is best for himself/herself. According to Williams & Lair (1991), lack of comparison to others makes person-centered play therapy a better model for working with disabled clients. Person-centered theory empowers the individual to seek the highest level of ability possible (Axline, 1948; Landreth, 1991; Williams & Lair, 1991). The therapist does not actively play with the child, but rather participates as an observer, encourager, and reflector of feelings (Axline, 1948; Landreth, 1991). Therapists following the nondirective approach believe that the child naturally seeks the positive I am identity, if given a permissive and safe environment to explore their feelings (Axline, 1948; Moustakas, 1959; Landreth, 1991).

Directive play has specific activities. The directive therapist believes that the I am of the child can best be explored through activities selected by the therapist and aimed at developing self-esteem, personal competency and self-reliance. For example, Irwin and McWilliams (1974) used a directive play therapy approach

using creative dramatics with children with disabilities. The children attended two hour-long sessions each week. The first week focused on a training period in which the children participated in rhythmic activities, pantomime and guided dramatic play. A second period of preparation involved having the children perform stories and nursery rhymes already familiar to them. The final phase consisted of the children's verbalized fantasies, original stories and expressions of fear (Irwin & McWilliams, 1974). Once the child's inner world is expressed, the therapist and other children can provide positive feedback to support the I am of the child.

Another method proposed by Gardner (1974; 1975) is mutual story telling. First, the child tells a story. Then the therapist retells a variation on the child's theme in which negative behaviors or emotions are replaced with positive elements. Through the therapist's retelling of the story, the child is subtlety guided to maintaining positive self-esteem, personal competency and self-reliance in the specific situation illustrated by the story. One example is The Story Telling Card Game (Gardner, 1988), a board game with a curved three color path from start to finish. Each color corresponds with

a specific deck of cards: talking, feeling, or doing. The child rolls the dice and moves ahead on the path. The color of the square the child moves to determines which type of card the child will draw. The cards have activities or questions written on them. The activities are aimed at helping children self-explore their feelings, expressions, and behaviors to clarify the I am attribute.

Gladding (1992) suggests that children be encouraged to express themselves through music, poetry, prose, and art. Children can either share the songs they like and what they mean to them or they can create original music. Electric keyboards, rhythms instruments, and pre-recorded melodies are helpful for the child with disabilities who want to express their feelings with music. The use of an audiotape recorder is used for children who may not be able to write their poems or original stories. Gladding (1992) also encourages the play therapist to have ample supplies of art materials for the child's selection. Children's creative work provide a method to view their inner world of fears, strengths and weaknesses. Once these fantasies have been externalize through creative arts, the therapist can use the material to strengthen

the I am personality construct.

I CAN EMPHASIS

The I can emphasis in play therapy focuses on the physical development of the child. The I can emphasis helps the child to test limits of physical disabilities and to go beyond these limits in learning new skills. An example is intensive play (Bradtke, Kirkpatrick & Rosenblatt, 1972), recommended for children with physical and sensory impairments. The purposes of intensive play are (a) to build awareness of self, others and environment; (b) to reduce fear of physical contact; and (c) to help the unresponsive child become responsive. A specific hierarchy of 30 physical activities are used, progressing from least threatening to most threatening to the child. The first step in the hierarchy is to pat the child's body in rhythm. The progression of activities ends with the adult standing, holding the child firmly by the ankles, and moving the child up and down so that the child's hands and head touch the floor. When the child has completed the activities with one adult, another adult is introduced and the cycle of activities are repeated.

Once the child becomes comfortable with the physical

activities with adults, child-to-child activities are initiated. These child-to-child activities are structured and supervised by adults to insure the protection of the children (Bradtke, et al, 1972).

Kraft (1983) included a broader range of activities that dealt with rhythms, body awareness, gross-motor skills, fine motor skills, eye-hand, eye-foot coordination, and swimming. Activities included finger snapping, body alphabet contortions, trampoline stunts, clay sculpturing, finger painting, ring toss and blowing up balloons. Sessions were short with a one-on-one relationship with the therapist.

In another study by Kraft (1981), a group therapy setting was used pairing hearing with hearing impaired children. The hearing partner was used to reinforce directions and to provide a model of social and physical skills. A trust exercise described by Kraft (1981) was Car and Driver in which one participant is a car and the other is the driver. The drivers place their hand on the shoulders of the cars and direct the blindfolded car around the room. The partners reverse roles so each can have the experience. Other suggestions include mirroring activities, mime stories, circle games, relay races, and

balancing games (Kraft, 1981).

Part of the I can construct is physical therapy focused on helping the child maintain or regain use of physical abilities. An example is Brien's (1977) recommendation of homemade play dough for the therapeutic manipulation of arms, shoulder or hands. Another suggestion by Brien (1977) is bubble blowing for loosening respiratory congestion. Macrame, mosaic tiles projects, string art, simple sculpturing, stringing beads, model making, crocheting and making popsicle stick furniture are part of the projects that occur

Lambie (1975) described toy library approach to provide opportunities for mastering certain physical skills, such as finger dexterity,. First, a diagnostic interview is conducted with the child and other family members present to assess the child's present skill level and identify toys which would facilitate improvement of skills. During the session, the therapist demonstrates the therapeutic toys. The toys are presented one toy at a time, with each toy addressing a specific skill the child needs to accomplish. The toy may then be checked out for use in the home. When the skill represented by the toy is mastered, the parents and child are provided

a new toy and instructions about its use.

ACCOMMODATIONS

Adaptation of the toys or toy selection aids the child with physical disabilities to become more independent and confident in the play room. Salomon (1983) suggested that children, who may not be able to grasp objects, have paint brushes taped to hands or elbows to paint in play therapy. Musselwhite (1986) suggested attaching sponges from foam curlers to brushes to make the brushes easier to hold. A special glove could be devised by gluing Velcro or magnets to it so the child might handle mental or textured items more easily. Dress up items can be chosen with the child with physical disabilities in mind. Items such as purses, hats, and scarves are easier for children with disabilities to manipulate. Bean bags may be preferred over balls for throwing, as bean bags do not roll away from the child's reach (Salomon, 1983). The author has bean bags shaped like frogs that are very popular with all children.

Suggested toys for children with cerebral palsy include: activity boards with beads, sliding panels, bells, wheels, and lights; a rummage box with a variety of toys, textures, sizes and shapes; sandbox or tray;

musical instruments such as bells, tambourines, drums, triangles, and wooden sticks (Darbyshire, 1980). A board with a collection of locks and latches has provided a very popular toy in the author's collection. These suggested toys are equally worthwhile for other special populations.

Palumbo (1988; 1989) designed a puppet to be easily used by a child with a profound disability. The puppet had a weighted base, a rod covered with a costume and a head. The puppet could be rocked back and forth making it animated. The puppet was easily used by children with physical or cognitive disabilities.

A second way to accommodate a child with a physical disability is through changes in the setting. Traditionally, the toys are arranged on shelves and the child may see the total selection at one time (Axline, 1948; Landreth, 1991). Bradley (1970) suggests that the toy selection be limited and introduced one item at a time to children who do not have the requisite skills to play or who have difficulty exploring their environment, e.g., visually disabled, motor disabled.

Darbyshire (1980) describes environmental accommodations for children who have cerebral palsy. The

child can be placed over a wedge or pillow with the toys within the child's reach. Other suggestions were that children who use a wheelchair have a variety of places to be moved from their chairs that will encourage different positions. Examples are beanbags and foam wedges (Darbyshire, 1980). The therapist might incorporate large stuffed animals as effective support for the child. One child found a large stuffed gorilla useful by placing the child in front of the gorilla and using the gorilla as support; another child found that lying across a large green frog provided the elevation necessary for playing while lying on her tummy.

Adaptations to toys must be made to create a safe and accessible environment. C-clamps can be used to stabilize a dollhouse on a table. Dolls placed on elevated trays can be helpful to the child needing minimized distances or range of motion. Musselwhite (1986) also suggests suspending toys on a frame over a chair or bed for children.

Through adaptations of toys and accommodations of the environment, the children achieve a degree of independence and competence not always available in other settings. The play room or setting becomes "user

friendly."

SUMMARY

In summary, play therapy with its emphasis on the I am and I can provides the child with those experiences that can help the child grow and develop his or her potential to the fullest. With a few accommodations to the toys and techniques, the developmental or health disabled child can experience play therapy.

Several recommendations are suggested by this article. The first recommendation is that play therapy be considered in the overall treatment plan by mental health and pediatric nurses in working with developmental and health disabled children.

The second recommendation is that the professional play therapist work with treatment team. Through the coordinated efforts of a treatment team approach, the needs of the developmental and health disabled child can be better served.

The third recommendation is that the parents or parent be involved in treatment when inclusion will benefit the overall treatment plan. As O'Connor (1991) states, the goal of including the parents is to have them as allies to therapy. O'Connor cautions that treatment

may pose a threat to the significant adults in the child's life, resulting in the significant adults seeing themselves as incompetent and responsible for the child's distress. If the significant adults are included in treatment, then they are invested in helping it be successful (O'Connor, 1991).

Play therapy provides the child with those experiences that can help the child to define who I am and what I can do. In such an environment, the child is nurtured to grow strong and independent with realistic goals and aspirations.

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